
# MDCH/EHDI
# Guide-By-Your-Side Program
# Referral Form

Child's Last Name: _____ Last Name at Birth: _____

First Name: _____ Birth Date: _____

Hospital of Birth: _____ ☐ Male ☐ Female Twin: ☐ A ☐ B

Parent's Last Name: _____ First Name: _____

Address: _____ Phone: (_____) _____

City: _____ State:_____ ZIP:_____

## Diagnostic Audiological Results

Right Ear _____ Type of Loss _____ Degree of Loss

Left Ear _____ Type of Loss _____ Degree of Loss

**Enrolled in *Early On*®?** Date:_____
**Enrolled in Special Education?** Date: _____

**Referral to the Guide-By-Your-Side Program ☐ Yes ☐ No**

I give my permission to release diagnostic audiological/medical evaluation results to my primary care physician and the Michigan Department of Community Health (MDCH) Early Hearing Detection and Intervention (EHDI) Program, and Children=s Special Health Care Services. Other collaborating MDCH programs also have my permission to assist with coordination of follow-up on behalf of my child. Diagnostic, follow-up, and intervention information can be sent to MDCH from participating agencies. Information will not be shared with unauthorized people or agencies not involved in hearing screening follow-up and/or intervention in conjunction with the MDCH Program.

Signature of Parent/Guardian: _____Date: _____

**FAX To: (517) 335-8036**
Telephone: (517) 335-8884
Mailing Address: MDCH/EHDI/GBYS
P.O. Box 30195
Lansing, MI 48909

Under HIPAA (164.512 (b) THE PUBLIC HEALTH EXCEPTION
-Covered entities may disclose data to Public Health Authorities for use in public health activities.
-Covered entities that are also Public Health Authorities may use data for public health activities.
-Authorization from patients is not required for these uses and disclosures.

Reporting diagnosed hearing loss is mandated under MCLA §333.5721.5805